CERTIFICATION OF SPECIALTY TRAINING

(This form applies only to applicants for specialty licensure)

As part of the license application process, the Idaho State Board of Dentistry requires that the school at which the applicant received her/his specialty training complete this form. The completed form must be mailed **directly from the school to the Idaho State Board of Dentistry.** Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name_____ **SSN#**_____

Signature_____ **Date**_____

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This portion of the form should be completed by the specialty program.

PLEASE DO NOT COMPLETE THIS CERTIFICATION FORM PRIOR TO THE ACTUAL DATE OF THE STUDENT'S PROGRAM COMPLETION.

IT IS HEREBY CERTIFIED THAT _____
(Name of Applicant)

RECEIVED DENTAL SPECIALTY EDUCATION AT_____
(Name of school)

LOCATED AT_____
(Full Address of School)

FROM_____ **TO**_____
(Month/Year) (Month/Day/Year)

GRANTED A DEGREE IN THE SPECIALTY FIELD OF _____

DATE DEGREE CONFERRED_____
(Month/Day/Year)

Was the program accredited by the Commission on Dental Accreditation of the American Dental Association at the time the applicant graduated? Yes_____ **No**_____

President, Dean, Secretary, or Registrar:

Print Name_____ **Title**_____

Signature_____ **Date**_____

Phone #_____ **Fax #**_____

Return Completed Form to:

IDAHO STATE BOARD OF DENTISTRY
PO BOX 83720
BOISE ID 83720-0021
Phone (208) 334-2369

School Seal